Babies' Etc., OB/GYN P.C.

235 Portal Lane Suite A
Madison, AL 35758
Office: (256) 461-1766 Fax: (256) 461-1766
Jacqueline Sylvester, MD

Authorization for Release of Medical Records to Another Facility

Patient's Name: _____
Address: _____
_____
Home Phone: _____
Date of Birth: _____
Social Security: _____

Babies' Etc., OB/GYN PC
235 Portal Lane Suite A
Madison, AL 35758

Phone: (256) 461-1766
Fax: (256) 461-1768

PLEASE NOTE: If you wish for you records to be faxed, you must initial here: _____ Please be advised that patient confidentiality **cannot** be guaranteed when faxing medical records. In the event the patient chooses not to initial the above, all medical records are requested to be mailed to:

_____
_____
_____

The medical records information will be used for continued medical care and/or treatment and should include:

- ☐ All medical records, i.e.: Labs, Pap Smears, and Delivery/Operative Reports between the period of _____ to _____.
- ☐ Hospital Admission (s) and Discharge Summary (s).
- ☐ Office Visit Notes Only.
- ☐ Last Office Visit Note & Lab Only.
- ☐ Other: _____

I acknowledge that the data to be released may include material that is protected by law. I also acknowledge that I have the right to revoke this authorization, in writing.
The written revocation must include:

- ☐ The patient's name, date of birth and address
- ☐ Initial date of authorization and the recipients of the protected health information according to this authorization.
- ☐ The patient's desire to revoke this authorization, the date of the authorization, and the patient's signature.

NOTICE: 30 days after accepting your revocation rights, Babies' Etc. OB/GYN PC will not be held liable for any medical condition (s) and /or treatment(s).
I acknowledge that any medical records received from another physician and /or organization, prior to my dates of treatment with Babies' Etc. OB/GYN PC, **will not** be forwarded to the physician and/or organization stated above. I will be solely responsible for obtaining those medical records in order to receive medical care and/or treatment from the physician and/or organization stated above. My check mark, initials, and/or signature may be used as authorization for the release of the above records.
NOTE: This authorization expires 30 days from the date indicated below.

_____ _____
(Patient's Signature and relationship) (Date)

_____ _____
(Staff Witness) (Date)